



Patient Information

Name (*print*): _____

Date: _____

Age: _____ Date of Birth: _____

Social Security Number: _____ - _____ - _____

Phone: (____) _____ - _____ Email: _____

Home Address: _____

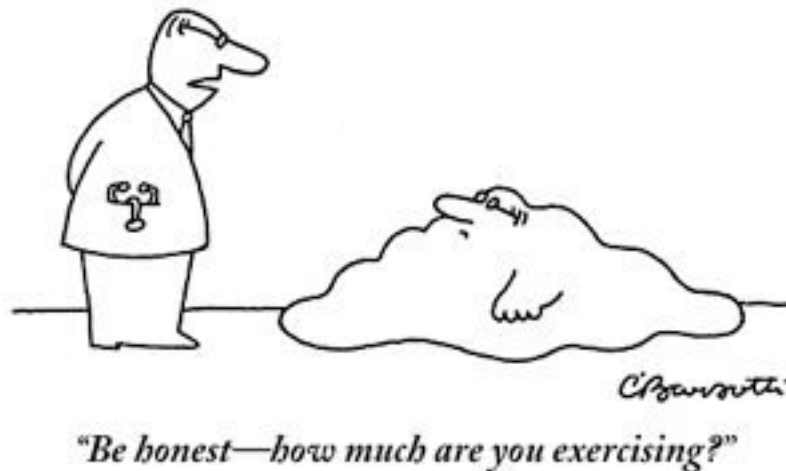
Zip Code: _____

Occupation: _____ For How Long: _____

Did someone refer you to our clinic? If so, please let us know so that we can thank them for giving us such a wonderful compliment:

Please describe your chief complaint(s) [*What brings you to our clinic?*]

On a scale of 1-10, how healthy would you that say you are? _____



Adult Consultation History



How long have you suffered with this problem? _____

What have you tried to do to get rid of this problem that **DID NOT** work? _____

Have you become discouraged about handling this problem? _____

When your problem is at its worst, how does it make you feel? _____

How does this problem interfere with the following area of your life?

Work: _____ Hobbies: _____

Family: _____ Life: _____

Does handling this problem cause stress for you? _____

What do you do that makes this problem worse? _____

How much older does it make you feel? _____

On a scale of 1 to 10, with 10 being the highest, rate your commitment in helping us solve this problem: _____

What gives you some temporary relief? _____

What is the pattern of this problem: Constant Daily On & Off Weekly Monthly

What is the effect that it has on your body functions? _____

Do you remember when/how it started? _____

If you are on any type of medication, *please list all:* _____

Are there any others that you can't recall at this time? Yes No

Have you recently been involved in an automobile accident? Yes No

Date of accident: _____ *Any difficulties from this?* _____

Do you have any children? Yes No If so, how many? _____

Would you like to receive a complementary gift certificate for a friend or family member to be examined by Dr. Tanase within the next 30 days? Yes No

Is there any other information that you would like us to know? _____

SIGNATURE: _____ **DATE:** _____

For Women Only

Date of your last menstrual period: _____

Are you using any means of contraception? Yes No

Do you experience severe cramping with your menstrual period? Yes No

Do you suffer from PMS? Yes No